Implementing the Community Occupant Protection Resource Directory to Influence Seat Belt Legislation on the Pine Ridge Reservation. David B. Cramer, Class of 1996.

The Pine Ridge Reservation is home to 20,000 members of the Oglala Sioux Tribe and some of the most dangerous roads in the country. Over the past two years, motor vehicle crashes on the reservation have claimed 30 lives, a motor vehicle fatality rate 3.5 times the U.S. average. Motor vehicle crash injuries are the leading cause of death for Pine Ridge adults in their 20s and 30s. There are many environmental factors influencing the extreme number of motor vehicle crashes on the reservation: narrow roads, wandering livestock, impaired drivers, poor snow removal. But many of the severe injuries are due to non-use of occupant restraints, i.e., seat belts and child safety seats.

In the fall of 1995, I was assigned the task of improving highway safety on the reservation. The reservation had no seat belt law and seat belt usage rates were as low as 5%. I had no experience with highway safety. However, in 1996 I received a copy of the Community Occupant Protection Resource Directory (COPRD). The COPRD is a manual written by the IHS, the National Highway Transportation Safety Administration, and tribal representatives. It is a guide for how tribal nations can increase safety belt and child safety seat use. The COPRD has 13 modules "designed to assist the user in establishing a coalition, generating support, developing a plan, implementing an effective community occupant protection program and measuring progress and results." This paper describes the year-long process in which I attempted to implement several of the COPRD modules with a major goal of obtaining passage of a primary seat-belt ordinance.

Community Assessment

The first COPRD module is called "Getting Started and Developing a Plan." Its purpose is to gather information about "injury and crash problems in the community, public's knowledge and attitudes about wearing safety belts and using child safety seats, and current legislative and enforcement actions about occupant protection laws." From this information, a plan of action can be developed to target time and resources. The book recommends starting out by forming a coalition/working group to help facilitate the collection of information. However, because we had access to a wealth of injury data at the Pine Ridge Hospital, we began collecting injury data.

Motor Vehicle Crash Injury Data

We determined who was getting hurt and killed through a surveillance system we established at the Pine Ridge Hospital. Clementine Tyon, the OEH Secretary, culled the emergency room log book for motor vehicle crash injuries, pulled the charts of crash victims, and entered the data into a computer using Epi Info Version 6.0. This data was useful in describing the severity, age, gender, nature of injury, time of injury, and whether or not alcohol was involved. Many times the medical chart contained an ambulance report that was helpful in determining crash locations, who was driving, and seat belt use. We set a goal to collect five years of past motor vehicle crash injury data. However, we found so many cases that we had to cut back our goal from five years to two. By July, 1996 we had collected 548 motor vehicle injury cases.

Collecting descriptive information about the cases (such as crash location and cause) proved substantially more difficult. Each month, the Public Safety Records Office would supply us police crash reports. However, when we matched the hospital data with the crash reports, we realized that only about one quarter of the reports were being written. Also, the police reports were often difficult to interpret. The BIA, the federal agency responsible for road construction on the reservation, did not have a mile marker system. The police officers, therefore, used non-standard locations such as "crash occurred ½ mile from John Smith's turnoff" in their crash reports. Finally, the reports were often illegible and did not contain a sufficient narrative to determine the cause of the crash.

From our data, we calculated a fatality rate of 70 per 100,000. This rate is over 3.5 times the national average. Alcohol involvement was noted in 54% of the crash reports. Children under five were over-represented in fatalities and severe injuries. Finally, although the cases were infrequent, we demonstrated that those individuals in seat belts walked away from car crashes 95.8% of the time. This information proved particularly important when we began forming a community coalition and testifying before the tribal council on the need for a seat belt ordinance.

From death certificate information and individuals familiar with the crashes, we developed a pin map of the fatalities. We found the map to be a catchy method of getting people to think about motor vehicle crashes. Often people would walk up to the pin map and discuss something they knew or had heard about a particular crash.

Determining the Cost of Motor Vehicle Crash Injuries

Using Module B of the COPRD, "*How Crashes Affect Your Community*", I took the standard cost of Emergency Room visits, hospitalizations and fatalities and estimated the amount of resources over a two-year period that were being lost due to motor vehicle crashes. I estimated the cost of injury to be $614,000 for emergency room visits, $6.5

million for hospitalizations, and $10.2 million for fatalities. Our Contract Health Office (responsible for paying for services at non-IHS facilities where many severe injuries are treated) estimated that two-thirds of contract health care dollars were going to treat trauma victims, mainly motor vehicle crash victims. The director further stated that due to the numerous severe trauma cases, Contract Health could not afford to fund most elective surgeries, such as cataract removal or orthoscopic surgery. These facts became a forceful argument for highway safety activities.

Knowledge and Attitudes

We recognized early in the project that some members of the community did not regard highway safety, particularly seat belt use, very highly,. During one meeting, a woman who seemed to be speaking for the group said, "if Tecashula (Lakota for God) intended for her to die on the highway, then so be it." A Council person who had been permanently disabled during a drunk driving crash remarked that a seat belt law was unnecessary and most cars didn't have them anyway. The chief of police said that there was little anyone could do to prevent car accidents, and his department was too busy working on assaults to be bothered with highway safety.

To determine residents' feelings about seat belts, I conducted a survey of CHRs and health fair participants using the seat belt opinionnaire in the COPRD. 57% of the respondents felt that wearing a seat belt could lead them to being trapped in a burning or sinking vehicle. 65% reported losing a close friend or relative in a motor vehicle crash. Thus, the community did not connect seat belts with saving lives, despite the many crash deaths on the reservation.

Using the Informal Local Survey guide and the seat belt survey form in "Module J Resources" in the COPRD, we conducted two observational surveys. In the summer survey, we looked at over 1,500 cars during a 3-day period. We went to the busiest intersection in Pine Ridge and looked for shoulder belt usage in front seat drivers and passengers. When out of state license plates were excluded, the seat belt usage rates were about 5%.

Current laws and enforcement policies

The COPRD recommends the user to take an inventory of the traffic safety laws and enforcement practices. We knew the tribe did not have a seat belt law. However, we were surprised at Public Safety's disregard for highway safety. During our seat belt survey, we found that none of the officers in their police cruisers wore seat belts. As a department, they focused on assaults and public intoxication despite an 11:1 ratio of traffic deaths to homicide.

Our inventory of the Pine Ridge Motor Vehicle Code revealed that most of the vital highway safety laws were on the books including provisions against drunk driving, speeding, and hit-and-run driving. However, due perhaps to low staffing levels, enforcement was more reactive than proactive: the police would respond to calls rather than patrol the highways for suspected drunk drivers. During FY 1996, 25 police officers made 11,650 arrests of which only 3.5% were for highway safety violations. The majority of arrests (64%) were for violation of the reservation's liquor restriction law (primarily public intoxication).

Forming the Work Group/Community Coalition

After establishing a data collection system, our next goal was to assemble a coalition/working group as the COPRD suggests: *"Experience in the U.S. and other countries shows that to achieve and maintain high levels of seat belt and child safety seat use, a combination of public information and education, legislation and enforcement is needed. This requires the support of the Tribal Council and tribal members. Forming a coalition of tribal members can help you gain support and identify strategies that will work best in your community."* I assumed this meant that a coalition was critical to the success of the project and that without the coalition, neither the tribal council, law enforcement, nor the community would support a seat belt ordinance or address the motor vehicle crash epidemic. I therefore devoted a substantial amount of energy to the formation of what has become known as the Pine Ridge Highway Safety Coalition (HSC).

Unfortunately, the COPRD did not discuss how to create a coalition. I had no experience in forming a coalition and little understanding of group dynamics and our first 2 attempts failed completely. We first tried to form a community coalition in February, 1996. We wanted to develop a coalition that would function without the leadership of the Pine Ridge Office of Environmental Health (OEH). We felt that community ownership would develop only if the coalition members decided where they wanted to concentrate their efforts. Therefore, we held a community forum and presented the leading injury problems--highway safety, violence, house fires, falls and suicides--to see which ones interested the participants. We invited influential individuals involved with creating policy changes that could reduce injuries. The guest list included the Housing Authority Director, Fire Chief, CHR, the IHS Service Unit Director, the BIA Superintendent, the President of the Oglala Sioux Tribe, Chief of Police, and clergy from local churches. I outlined the Pine Ridge Reservation injury epidemic and then opened the meeting for discussion. Unfortunately, the IHS personnel spoke the most. When the meeting adjourned, the chalkboard was full of notes ranging from seat belts to smoke detectors. No one from the community was interested in forming a coalition.

From this first experience we learned that our focus was too broad. Our goal was to reduce motor vehicle injuries, so we scheduled another organizational meeting the following month. This time we invited individuals whose position was primarily concerned with highway safety. I visited each of them before the meeting, so everyone knew exactly why we were meeting and what we were attempting to accomplish. Since we still hoped that the community would develop ownership, we held the meeting in a conference room away from the IHS Hospital and agreed in advance to let the people do most of the talking. Although we had a 2-hour period set aside for the meeting, we never got past the introductions. At the outset, there was an emotional exchange between the Chief of Police and the aunt of a child killed in a car crash regarding an officer's behavior at the scene of the crash. From there, the meeting devolved from highway safety to HIV problems and the break up of the traditional Lakota family. Again, the meeting adjourned with no plans for a coalition.

A monograph by Larry Cohen, "Developing Effective Coalitions: An Eight-Step Guide," helped us to see our errors. We had been overly timid about our role in the coalition, had not been clear about our intentions, had chosen individuals who perhaps didn't have the time to participate in the coalition, and needed a facilitator to manage the meetings. The monograph states: "The lead agency convenes the coalition and assumes significant responsibility for its operation. To succeed, the lead agency should arrive at the first meeting with a strong proposal for the coalition's structure, including its mission and membership. Although many of the components of a coalition's structure are negotiable, the lead agency should be clear about the particular elements that are not." Our primary concern had been not to appear to be forcing our will on the community. But we had gone too far in abdicating our role in providing leadership. The article also addresses membership. It says, "on the other hand, line staff are frequently more committed, enthusiastic and available than top leaders and are often more in touch with the issues related to hands-on service delivery." Finally, we learned about the need to recruit a good facilitator who is "knowledgeable in group dynamics and comfortable with the task of including disparate members in group interactions, fostering group discussion, and resolving disagreements within the group."

By the end of the summer, we were back forming the HSC. In our invitations, we achieved a better balance between program directors and staff. For example, instead of inviting the Chief of Police, we identified two officers out in districts who had shown an interest in presenting a defensive driving course. We also sought a balance between talking and listening. I made a speech on highway safety issues, then invited the participants to offer suggestions on how to reduce motor vehicle injuries. The IHS Community Health Director served as our facilitator. When the meeting began to stray, she brought it back to the topic. At the end of the meeting, the group unanimously agreed to form a regularly meeting body and the Pine Ridge Highway Safety Coalition was formed.

Writing the Community Occupant Protection Plan

The COPRD details the development of an action plan. The plan includes a Statement of Need, Project Goal, Objectives and Actions Steps, Responsible Party, Budget, Time-line and Evaluation. Unfortunately, the COPRD doesn't say who is to write the plan., although it implies that the working group/coalition should write it. Therefore, I arranged a coalition meeting to develop a plan.

The meeting can best be described as a free for all. There was an agenda. But the IHS Community Health Director, our now *de jure* facilitator, could not attend, so the meeting deviated from the agenda at the outset and never returned. At one point, a participant likened the citizenry of Pine Ridge to those of Sodom and Gomorrah recommending that the town be burned. Many of the Pine Ridge people were insulted and nearly walked out.

We scheduled another planning meeting in Kyle, a community 50 miles from our normal meeting place. Unfortunately, the meeting date fell too close to Thanksgiving, the weather was bitterly cold, the start time was 6:00 PM and the location was an hour away from Pine Ridge where most of our regulars resided. Only 3 coalition members came. The rest were curious Kyle community people and members of the local Mother's Against Drunk Drivers chapter. I spent the entire session presenting highway safety themes and not strategizing as planned.

The COPRD had emphasized that the coalition develop the action plan. However, inconsistent attendance and competing personalities were frustrating these efforts. Again we consulted the literature. The section of the IHS injury prevention Level One Practitioner's course on developing coalitions includes, "*Tips on Organizing Community Action Programs"*. Among the main suggestions is that the person convening the coalition should "map out a tentative campaign plan. List in a probable sequence the possible events and activities which would carry out the goals and objectives of the project." The group would have approving authority over the plan, but at least it would be written. I then spent 3 weeks writing a plan of action for 1997. In January, I called a coalition meeting with only core members who had consistently appeared at previous meetings. The small group approved the plan and made further additions to it. In February, we held a full coalition meeting which gave the plan it's unanimous approval. The meeting was so successful that we never completed our full agenda due to the amount of

discussion surrounding a poster contest/sign campaign. The plan has evolved and been changed to fit circumstances, but at least there is a point from which we are working and a common goal.

Implementing Activities

Once a community assessment has been completed, coalition formed, and plan developed, the COPRD suggests marketing the seat belt message. We developed a presentation that combined local injury data with the COPRD's facts. I have given this presentation to civic groups, schools, CHRS, health fairs, parent organizations, police officers, and three radio interviews. Children relate to the description of running full force into a pole equaling the force of a 15 MPH crash; crash cost estimates resonate with adults. The COPRD's talking points allowed me to dispel myths such as wearing a seat belt will result in drowning or burning up in a motor vehicle crash. It also allowed us to show that other reservations were working on highway safety issues.

Once I began speaking on highway safety, I found that I could not focus entirely on seat belts. Most individuals on the reservation (including many of our coalition members) did not use seat belts. We had to find another highway safety initiative to generate interest. The coalition developed activities for Drunk and Drugged Driving Prevention Month in December. We wrote a tribal proclamation for the President's signature, prepared a press release and acquired red ribbons from the Governor's Office of Highway Safety. Four newspapers covered our press release including the Associated Press wire service. The Proclamation-signing ceremony was broadcast on Fox-TV News in Rapid City and carried live over KILI-FM. The coalition distributed over 2,000 red ribbons, held victim-impact forums at three reservation high schools and participated in a drunk-driving victims memorial walk in Porcupine, South Dakota.

The Seat Belt Ordinance: The drunk driving activities helped establish the coalition's credibility with the Police Department, Tribal Council and community at large. This momentum has allowed the coalition to promote passage of the seat belt ordinance. Using the example in the COPRD, we wrote the proposed ordinance as a primary enforcement law and included a 1-year grace period (similar to the Navajo Nation's) for community marketing and training of law enforcement officers. We sent the ordinance to a Tribal Council Member with a letter detailing the need for its adoption, including crash statistics. We had the HSC present crash information to the Tribal Council Health and Human Services Committee. After our presentation, the committee unanimously adopted the ordinance and sent it on to the Judiciary Committee. The Judiciary Committee amended the ordinance, then passed it. The ordinance is scheduled for a full council vote next month.

Discussion and Recommendations

The COPRD proved to be an outstanding resource for promoting highway safety on the reservation. It helped guide me to understand the community's attitudes toward occupant restraints, collect crash and injury data, determine seat belt usage rates, and gain a working knowledge of crash forces and seat belt systems. It also provided talking points and ideas to promote the seat belt law. My main criticism is the manual's lack of guidance on coalition building. The introduction states that the COPRD "is designed to assist tribal representatives in establishing a coalition." However, the book does not address such basic questions as whom to invite, how often to meet, meeting length, bylaws, the decision-making process, what to do if people don't show up, competing priorities within coalition member's schedules, members not completing assignments, personality conflicts, leadership, who should do the planning, and time involved in assembling a coalition.

The COPRD stresses the importance of a community coalition in promoting highway safety initiatives. However, developing a coalition involves a substantial commitment in time and resources. The COPRD provides enough information for a motivated individual with limited time to become a true highway safety advocate and achieve tangible results working *without* forming a coalition. Anyone interested in highway safety initiatives should not be dissuaded from taking action due to the inability to form a community coalition.

The agency promoting the coalition's formation should take a leading role in planning and facilitating the coalition. I did not want to make plans for the group or decide the group's priorities, thereby leaving the group feeling that the project was solely an IHS undertaking. However, the group was looking to me to provide ideas and expertise in an area that few had considered important. It was not until I began to play a leadership role in developing "tentative" plans and suggesting priorities that the group began to move from discussing activities to implementing them.

I recommend that the COPRD be re-edited with a section deicated to developing a community coalition. The section from the IHS Injury Prevention Practitioner's Level One Course, called "Tips on Organizing Community Action Programs" by Linda Mack, could be easily added in Module A. The authors should also refer to "Developing Effective Coalitions - An Eight Step Guide" by Larry Cohen.

In conclusion, the Community Occupant Protection Resource Directory is a treasure chest of information for anyone promoting highway safety in Indian Country. The examples are relevant for tribal communities looking to

save lives and scarce resources. I believe that anyone, from a community volunteer to the director of a health center, will find the book useful to their injury prevention program.